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ABSTRACT

This monograph reports the results of an effort to assess the experiences of family members and professionals who have received family/professional collaboration training and provides an evaluation of the training program and a discussion of the nature of collaboration. The fundamental concept underlying the training curriculum was the pairing of family members and professionals to participate in exercises promoting collaborative problem solving, communication, and advocacy skills. Primary training objectives included the identification by participants of potential attitudinal and systemic barriers to collaboration, knowledge and skills related to collaborative relationships, and the practice of these skills through experiential exercises. The curriculum used co-trainers consisting of both a professional service provider and a parent of a child with an emotional disorder. Fifty-two individuals (24 family members, 24 professionals, and 4 "dual respondents" i.e., each was both a family member and a professional) who had participated in the family/professional collaboration workshops completed questionnaires; 36 of the individuals also were interviewed. Quantitative and qualitative findings are summarized. Overall, the findings suggest that participants found the training to be of great value. Specifically, the identification of attitudinal and service system barriers, practicing various skills, demonstrations, exercises, and hand-outs were all rated highly by respondents. The dominant theme emerging was that collaboration is only partially developed as a concept and only partially applied as a practice. An appendix provides a copy of the survey questionnaire. (Contains 33 references.) (DB)

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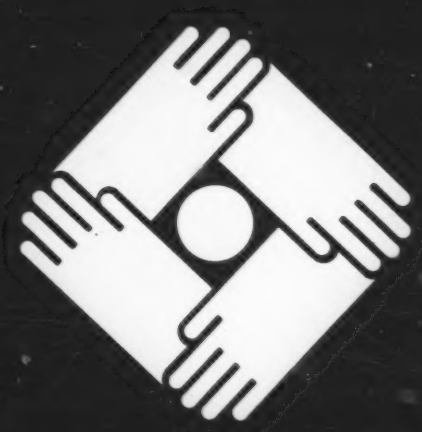

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Family/Professional Collaboration: The Perspective of Those Who Have Tried

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Family/Professional Collaboration: The Perspective of Those Who Have Tried

INTRODUCTION

The words "family/professional collaboration" have become fairly common in discussions of children's mental health services. While collaboration is often spoken of favorably, many practitioners, administrators, and policy makers are unsure how to achieve it in family/professional relationships. One way of addressing this gap in knowledge is to study the experiences of those who have tried to implement collaborative principles in practice. This monograph reports the results of an effort to assess the experiences of family members and professionals who have received family/professional collaboration training. The study serves as both an evaluation of the training and an attempt to explore the nature of collaboration.

BACKGROUND AND LITERATURE REVIEW

Over the past several years the notion of family/professional collaboration has received increased attention in children's mental health and related fields. In this context, collaboration is generally understood to mean that the family members of children with emotional and/or behavioral disorders and professionals work in partnership on behalf of the children. Collaboration is based upon the awareness that families have unique knowledge and can be a valuable resource in the understanding and treatment of a child's disability.

The recent focus on collaboration appears to have arisen primarily as a result of families' long standing dissatisfaction with services provided to them and their relatives with emotional disorders. Families have often felt blamed for the illness of a family member or alienated from the professionals providing treatment. Other important factors contributing to increased interest in collaboration include: (1) the general rise in consumerism of the past few decades, (2) research evidence discrediting theories of family interaction as causative agents of emotional and mental disorders and supporting the biological etiology of the most severe disorders, and (3) the reality of shrinking resources within the formal service system which has necessitated the utilization of informal resources in service planning and delivery.

While the concept of collaboration initially met with some resistance, there is a growing acceptance of family/professional collaboration as an important guiding principle in the delivery of services (Collins & Collins, 1990; DeChillo, 1989; DeChillo, 1993; Group for the Advancement of Psychiatry, 1986; Grunebaum, 1986; Hatfield & Lefley, 1987). Further evidence of this acceptance are the numerous reports discussing or proposing elements of

collaboration (Bernheim, 1990; Cournoyer & Johnson, 1991; Dunst, Johanson, Rounds, Trivette & Hamby, 1992; DeChillo, Koren & Schultze, in press; Dunst, & Paget, 1991; Friesen, 1989; Friesen, Koren & Koroloff, 1992; Hatfield, 1979; Lamb, 1983; Petr & Barney, 1993; Spaniol, Zipple & Fitzgerald, 1984; Vosler-Hunter & Exo, 1988).

The discussions in the literature run parallel to legislative mandates and policies that attempt to promote collaboration among families and professionals. In 1975, the Education for All Handicapped Children Act (P.L.94-142) mandated parental involvement in the development of Individualized Educational Programs (IEPs). Subsequent legislation, including the Education of the Handicapped Act Amendments of 1986 (P.L. 99-457) and Individuals with Disabilities Education Act (IDEA) enacted in 1990, upheld the tenets of family participation initiated by the earlier legislation. For example, regulations governing Public Law 99-457 (Amendments to the Education of the Handicapped Act), require that "assessment, service planning, and interventions must be done with the full participation and agreement of the family members of the child" (Nash, 1990, pg. 318). At the policy level, a number of initiatives emanating from the Office of Special Education Programs (OSEP) and the National Institute on Disability and Rehabilitation Research (NIDDR), U.S. Department of Education, have promoted family participation in various programs in the field of education. Similarly, the National Institute of Mental Health, U.S. Department of Health and Human Services, instituted the Child and Adolescent Service System Program (CASSP), which states as a core principle that families of children with serious emotional disorders must be full participants in all aspects of planning and delivering services.

While it is increasingly accepted that families should have an integral voice in the development and implementation of services for their children, actualizing family involvement is not always easy. Family members report having limited influence in working with professionals despite legislative mandates and agency policies that affirm the need for families' expertise (Turnbull & Turnbull, 1985). Brinkerhoff & Vincent (1986) observed that "analyses of IEP meetings document that family members are not active, equal participants at the meeting" (pg. 46). Thus, while the need for collaboration has been recognized in the field, there is reason to believe that it still occurs at only a minimal level.

One approach to addressing this problem is training. One of the earliest references to family/professional collaboration training is that of Dick, Moulin, Pellegrini & Traub (1988). These authors surveyed thirty-six separate family/professional collaboration trainings that focused on transition planning. The format of the 36 programs included one of four models: (1) a lecture with small group discussion and applied activities; (2) an orientation meeting; (3) one-to-one family member training with no formal group meeting; or (4) a trainer of trainers model where *families* were trained by professionals or by a combination of professionals and family members. The majority of the projects conducted a "one-shot" training (p.14) where information was given to participants in one afternoon or evening session. The information

most frequently provided concerned laws, agencies and services, and the IEP and/or ITP (Individualized Transition Program) process. The majority of participants in the thirty-six programs were Caucasian, middle class and high school graduates; however, while a lack of ethnic diversity was common to the projects, about one third offered trainings in Spanish.

In each of the 36 programs the participants completed an evaluation immediately following the training. "A majority of the programs surveyed reported that, as a result of the training, family members became more informed consumers, increased their knowledge of services, and became advocates for their children" (p.20). Professionals benefited in that they "felt better prepared, more knowledgeable regarding services, acquired strategies, became more involved with special or vocational education, and became more collaborative" (p.20). It is important to note that of the 36 programs, some involved joint training of families and professionals, and others trained families and professionals separately.

Friesen & Schultze (1992) conducted a nationwide survey of professional education programs to identify the extent to which family/professional collaboration content was included. In general, the survey of schools of medicine, social work, nursing, psychology and special education revealed few programs which included collaboration content. The exceptions were a few special education programs. For example, programs at the University of Cincinnati and San Francisco State University were designed to develop productive communication and negotiation skills between families and professionals. The San Francisco State program, as well as programs at San Diego State University and John Hopkins University, were designed to empower families and professionals to collaborate with each other, and across agencies, in order to facilitate interdisciplinary communication and cooperation, thereby improving service delivery. Finally, programs at both Alabama A & M University and Bemidji University emphasized cooperation and coordination between families and teachers to enhance successful interaction.

Doyle and Guttierrez (1988) developed a curriculum entitled *Parent-Professional Collaboration* in which they attempted to train families and/or professionals in the elements of collaborative practice. The objectives of the two and one-half hour seminar were to: (1) become familiar with the history, philosophy and definition of parent-professional collaboration; (2) identify the many professionals involved in supporting families of children with disabilities; (3) develop an awareness of the feelings which family members have toward professionals and vice versa; (4) identify the qualities of a collaborator; and (5) develop goals for skill building in collaboration (p. 12). Each of the objectives was met through presentation strategies consisting of one of several structures, including lectures, individual activities and small and large group discussions.

Edelmen, Greenland & Mills (1992) designed a collaborative training workshop specifically in the area of children's mental health. The main goals of their three and one-half hour session

were to: promote an understanding of collaboration; identify collaboration barriers; identify and practice strategies for building mutual trust and respect; clarify roles and expectations; learn to communicate assertively, solve problems and resolve conflicts; and identify ways to improve collaboration. Activities involved large group discussion, brainstorming sessions, and individual and paired role plays.

THE WORKING TOGETHER CURRICULUM

The final collaboration training approach to be discussed here is covered in some detail, since it is the basis for the research. In order to facilitate the growth of family/professional collaboration in children's mental health services, the Families as Allies Project of the Research and Training Center on Family Support and Children's Mental Health at Portland State University developed a family/professional collaboration training curriculum entitled *Working Together*. Developed in 1987, through funding provided by the National Institute of Mental Health and the Division of Maternal and Child Health, U.S. Department of Health and Human Services, the curriculum was designed to be a two and one-half day training for a joint audience of professional service providers and families whose children have emotional disabilities.

The fundamental concept underlying the curriculum was the pairing of family members and professionals to participate in exercises that promoted collaborative problem-solving, communication, and advocacy skills. Given the relative paucity of published materials at the time specific to family/professional collaboration in children's mental health, the training exercises and supporting materials were developed in consultation with families of children with emotional disabilities, representatives of family support and advocacy organizations, state CASSP directors, and members of the State Mental Health Representatives for Children and Youth (SMHRCY). The curriculum development was also enhanced by the adaptation of previous training materials developed by the Families as Allies Project to promote advocacy skills for families (Kelker, 1987a; Kelker, 1987b; McManus & Friesen, 1986). Principles of adult learning (cf., Annett & Sparrow, 1985; Kolb, 1984; Mumford, 1986; Perry & Downs, 1985) emphasizing small group interaction, values clarification, and skill transfer techniques were incorporated into the overall design of the curriculum and specific exercises.

The primary objectives of the training included the identification by participants of potential attitudinal and systemic barriers to collaboration (e.g., attitudes concerning the etiology of emotional disorders, previous negative experiences receiving or providing services, and service funding and policy barriers), knowledge and skills related to collaborative relationships (e.g., joint problem-solving, two-way communication, and shared planning and decision making), and the practice of these collaborative skills through experiential exercises. In addition, material was presented concerning the development of joint advocacy skills to both improve

individual services and to initiate service system reforms, the development of family support and advocacy organizations, and emerging models of service delivery (e.g., wraparound services, individualized service plans, and integrated, multi-agency planning and service implementation).

While some presentation of information was provided through didactic lecture, particularly concerning information on the nature and etiology of emotional disorders and emerging national trends in children's mental health services, the majority of the training was conducted through small and large group interaction in structured exercises, role-plays, and discussion. Buckley and Caple (1990) note that the use of simulation is a preferred method in training for replicating real life situations, stimulating creative thinking and participant motivation, and using participants' own experiences as a source of learning and critical reflection. For example, in one exercise introduced early in the training, family members and professionals formed separate groups to identify characteristics and behaviors of the other that both inhibit and enhance collaborative relationships. Under facilitation by the trainers, the entire group then reviewed these responses to identify common themes, reveal stereotypes, and discuss the shared responsibility of collaborative relationship building. Following the large group discussion, professional and family member participants formed dyads to discuss their reactions and experiences in an intimate, one-on-one environment. Similarly, a number of role-play scenarios involving families and professionals working together to plan services were presented in small groups to provide participants with practice in collaborative communication and problem-solving skills. Small group activities involving tactile objects were also employed in which mixed groups of families and professionals created physical representations of various aspects and values of collaboration. Such symbolic exercises served to promote interpersonal trust and communication between participants through their engagement in low-risk, creative, and enjoyable activities.

A unique feature of the curriculum was its reliance on co-trainers consisting of both a professional service provider and a family member whose child had an emotional disorder. In addition to the practical benefits of multiple trainers for guiding large group discussions, facilitating small group exercises, and dealing with situations in which highly reactive personal issues may be generated by individual participants, the use of professional and family member co-trainers provided participants the benefits of observing the consistent modeling of a collaborative relationship. By their use of personal experiences, example and demonstration, family and professional co-trainers increased the relevance of the training experiences and lecture materials for workshop participants.

To initially disseminate the *Working Together* model, state CASSP and SMHRCY representatives selected fourteen pairs of service providers and families from the western, southern, midwest and northeast regions of the United States to participate in a week long training of trainers, held in Portland, Oregon in 1987. To further disseminate the model,

Families as Allies staff and the fourteen pairs of trainers were contracted to provide four regional workshops, during the next two years, in cooperation with state CASSP directors, mental health and special education officials. In total, 87 pairs of family members and professionals (174 individuals) were trained in the principles of family/professional collaboration from 1987 to 1989. These trainings were funded by state and local CASSP projects, professional organizations, public and private service agencies, and family support and advocacy organizations.

While the *Working Together* curriculum was very well received by the families and professionals who participated, there was no formal follow-up evaluation in the intervening years prior to this study. However, the group of 174 individuals represented a unique group who had been trained in one approach to collaboration and who potentially had acquired several years of experience in applying what they had learned to everyday practice. Therefore, a study was undertaken in 1993 not only to evaluate the experiences of these individuals vis-a-vis the training but also to explore aspects of family/professional collaboration that could only be learned through experience. Specifically, the study was designed to assess: (1) the participants' experiences in the training; (2) the strengths and limitations of the training procedures; (3) the usefulness of the content provided; (4) the extent to which the training influenced practice; (5) barriers to collaboration experienced by the respondent; and (6) their thoughts about the elements of collaboration. In addition, the study included a qualitative component that provided an opportunity to explore views and opinions that participants may have developed about collaboration in the intervening period. Of particular interest here were opinions about the extent to which: (1) collaboration is equivalent to being a good counselor; (2) being collaborative is instinctual, an attribute which some have and others do not; (3) negative consequences were experienced due to attempts to be collaborative; and (4) cultural factors influenced collaboration.

METHODS

Instrument Construction. A questionnaire (see Appendix I) was developed for the study to address the research issues described above. Questions asked for quantitative ratings using Likert scale responses, dichotomous responses (Yes/No), or open-ended comments. In addition, the questionnaire included a number of items assessing the demographic characteristics of the respondent.

Data Collection. From the complete list of 174 families and professionals (87 pairs) who participated in the Family/Professional Collaboration workshops, current addresses were available for 137 individuals. Since the time of their participation in the workshops, some of the participants had changed their home addresses and their places of employment, and efforts to locate them were unsuccessful; they were therefore not available for inclusion in the sample.

The questionnaires were distributed in July, 1993. The questionnaire packets included the questionnaire, a form to supply mailing information, and two business reply envelopes--one to anonymously return the questionnaire and a second to return the mailing information form to receive a complimentary publication as a thank you for participation. The complimentary publication was the Research and Training Center's *Annotated Bibliography: Collaboration between Professionals and Families of Children with Serious Emotional Disorders.*

An additional question on the mailing information form asked individuals if they would be willing to discuss their thoughts concerning collaboration in a brief (20 - 30 minutes) telephone interview. Those who consented to participate in this interview were also asked to provide telephone numbers on their mailing information. The response rate for the questionnaires was 37 percent (n= 52).

Following the return of the questionnaires, those respondents who agreed to participate in the telephone interview (n=44) were contacted to set up a convenient time for the interview. Each respondent was then mailed a copy of the questions being used in the interview along with a reminder of the date and time of the interview. As described above, these questions focused on: (1) whether collaboration is equivalent to "good practice"; (2) the instinctual nature of collaboration; (3) negative consequences due to attempts to be collaborative; and (4) cultural influences on collaboration. The qualitative interviews were conducted over a two month period. A total of 36 interviews were completed, 71 percent of the original study sample.

DEMOGRAPHIC CHARACTERISTICS OF THE SAMPLE

Characteristics of the Sample. The 52 respondents to the questionnaire were evenly divided between family members (n=24) and professionals (n=24). Four respondents indicated that they attended the training as both a family member and professional; this group is henceforth referred to as "dual respondents."

Families. Twenty-four respondents were individuals whose children had emotional or behavioral disorders and who represented families within the training dyads. The great majority of the family respondents were mothers (85%) and the remaining family respondents were either stepmothers (5%), fathers (5%), or foster-mothers (5%).

Professionals. The sample of professionals comprised twenty-four people. Over one-half (54%) of the professional sample was female. Two-thirds of the sample (67%) was Caucasian and one-quarter (25%) was African American. The remaining professional respondents (8%) did not indicate their race. Almost all of the professional respondents (95%) held advanced

degrees. The great majority (86%) had a Masters of Social Work or Masters degree in another field. Nine percent held either a doctorate or a juris doctorate degree. The remaining respondents (5%) held a bachelor's degree or did not indicate their level of educational attainment. Half (50%) of the professionals were social workers. Occupational therapist, management consultant and training consultant were other professional titles represented by professionals in the sample. Sixty percent of professionals reported that their primary job function was administrative. Counseling/therapy (22%) and teaching (4%) positions were next most frequently cited as respondents' primary jobs.

Dual Respondents. Four respondents attended the family/professional collaboration training as both a family member and professional. Three of the four respondents were Caucasian females; the fourth was a male Caucasian. Two held Masters degrees; one of which was a Masters of Social Work degree. One of the remaining respondents held a Bachelor of Arts degree and the final respondent did not indicate her educational attainment. Primary jobs for the dual respondents were cited as research, counseling, teaching, and administration. Their professional titles were: researcher, counselor, case manager and advocate.

FINDINGS

The findings are reported here according to the topical sections of the questionnaire. Within each topical area, the findings from all respondents are reported and, where appropriate, the responses from the family and professional samples are reported separately and compared.

Quantitative Findings

Components of the Training. Presented in Table 1 are the findings from the family and professional respondents regarding the importance of the elements of collaboration training. As seen in Table 1, both families and professionals rated each of the elements of the training curriculum as being relatively important. On a scale from 1 to 4 (1=Not Important, 4=Very Important) all the elements of the curriculum received a rating above 3.24. The most highly rated training elements for families were: identifying attitudes which are barriers to collaboration; practicing problem solving and negotiation skills; and developing strategies to promote collaborative practices. The most highly rated elements for professionals were: the identification of attitudes; identification of system level barriers; and practicing problem-solving and negotiation skills. To compare ratings of families and professionals for each element, a mean rating for each element was computed, and the means for families and professionals were compared using t-tests. No statistically significant differences were found between the families and professionals in ratings of the importance of the elements of the collaboration training.

TABLE 1. Comparison of family and professional respondents' mean scores and standard deviations for ratings of the importance of training elements.

	Family respondents		Professional respondents		
Variable	*M*	*SD*	*M*	*SD*	*t*-value
Identification of attitudes which are barriers to collaboration	3.83	.48	3.83	.48	0.00
Identification of service system barriers	3.62	.49	3.83	.48	1.48
Practicing interpersonal communication skills	3.58	.77	3.67	.64	0.41
Practicing problem solving/negotiation skills	3.75	.53	3.79	.67	0.24
Developing strategies to promote collaborative practices	3.71	.55	3.67	.56	0.26
Demonstration of collaborative skills by trainers	3.50	.66	3.67	.48	1.00
Group Exercises	3.46	.72	3.62	.65	0.84
Handouts and other written material	3.37	.58	3.25	.68	0.69
Practicing skills for personal advocacy	3.67	.56	3.42	.83	1.22
Practicing skills for system advocacy	3.62	.58	3.62	.71	0.00

In addition to the questions asking respondents to rate the components of the training, the survey also included four open-ended questions asking participants to provide their assessment of what other major concepts or skills should have been addressed in the family/professional collaboration training, what they believed the overall strengths and weaknesses of the training curriculum were, and how many people they had trained following their training. Respondents were not limited in the number of responses to each open-ended question, therefore total percentages for each question may exceed 100.

First, respondents were asked to list additional elements or areas that they thought would have enhanced the training. Nine respondents (16%) out of the total sample responded to this question. Respondents were evenly divided between families (n=4) and professionals (n=4), and one dual respondent. Two respondents (one family member and one professional) believed that instruction in self-esteem building would have enhanced the training. One dual respondent and one family member (n=2) noted that information on concepts related to family-centered practice would have been a beneficial addition to the curriculum. Other individual responses (n=5) to this question included requests for a definition of emotional disorder, information about theories of social and behavioral styles, information on multicultural issues, instruction on implementing mutual goals, and ideas about developing purpose and mission statements.

Respondents were also asked what they thought was the most important skill or information they received at the training. Seventy-nine percent (n=42) of the total sample responded to this question. Roughly half (n=19) were families and half (n=20) were professionals. Three respondents to this question were dual respondents. Just over one-half of the professional respondents (n=11) and just fewer than half of families (n=8) who responded believed that practicing skills for competency in effective communication, assertiveness, group interaction and system and personal advocacy were the most important aspects of their training. One dual respondent also believed that practicing skills was the most important aspect of the training. About one-fifth (n=8) of the respondents, four of whom were family members and four professionals, thought that learning to value each person's experience and recognizing and respecting the life stage or cycle a professional or parent is in was the most important skill acquired from the training. Another important aspect of the training for a few families (n=3), one professional and one dual respondent, was learning how to teach concepts of family/professional collaboration to others. Two professionals and two family members (10%) valued information on system change and issues related to empowerment. Two respondents, including one family member and one professional, thought that learning appropriate attitudes for collaborating was valuable. Information on available resources was important for one professional and one family member. Other individuals valued the duration of the training; learning how to develop strategies promoting collaboration; gaining insight into the historical perspective of collaboration, and understanding one's own feelings of anger, guilt, fear, or denial. Finally, one dual respondent thought the most important aspect of the training was

listening to people of various regions discuss commonalties about their attempts to collaborate.

The final open-ended question evaluating the training asked survey respondents to provide their opinions about the training's weaknesses. Fifty-one percent (n=27) of the sample answered this question. The respondents were evenly split between professionals (n=13) and families (n=13) and one dual respondent. Thirty percent of the respondents to this question (n=8), five of whom were families and three who were professionals, believed that there was not enough time provided for different activities in the training, and one of the eight thought the entire training could have been extended. Twenty-two percent of the respondents (three professionals, two families and one dual respondent) thought that a weakness of the training was the lack of follow-up information provided to participants of the trainings. Four people, evenly split between families and professionals, remarked that a weakness of the training was the extent to which trainers minimized the negative attitudes that one experiences while trying to collaborate. Three respondents believed that the training was vague or lacked clarity, and two others cited weaknesses in the workshop preparation. Individual respondents cited the out-of-state nature of the training, lack of facilitation, limited exposure to teaching strategies, and the unavailability or inaccessibility of the training as other weaknesses.

Survey respondents were asked how many other people they had trained since participating in the train-the-trainer workshops. The majority of respondent (63%) indicated that they had trained others since their own training. Seventy-one percent of professionals, 63 percent of families, and half of dual respondents had provided training. Regarding the number of persons trained, the responses ranged from four to 3,000 per year with no discernible pattern among the respondents.

Influence of the Training. The survey examined the extent to which the training influenced activities in advocating for and/or supporting families who have children with emotional or behavioral disabilities. Families and professionals agreed that many of their advocacy and support activities, had, in fact, been influenced by the training. Assisting another family was the activity that was most influenced by the training for both groups. Families, however, assisted other families to a greater degree than the professional participants. Twice as many families (n=18) as professionals (n=9) contacted a school or other agency because of the training. Over one-half (n=16) of the family members said they attended a hearing and half (n=12) of families made a speech or wrote an article as a result of the training. Only one-quarter (n=6) of the professionals said they served on a mental health advisory board compared to more than one-half (n=13) of the family members who had participated in this activity as a result of the training. About one-half (n=12) of the families and slightly over half (n=14) of professionals organized an advocacy group. Twice the number of families (n=10) as professionals (n=5) prepared testimony as a result of the training. Less than ten percent of both families (n=2) and professionals (n=1) filed a formal complaint as a result of the training. It should be noted that the differences in percentages between families and

professionals concerning the influence of the training could be due to the fact that professionals may already have been involved in many activities included in our list.

Elements of Collaboration. The third section of the questionnaire asked respondents their opinions about the elements of collaboration. Respondents were asked to indicate their agreement or disagreement with nine elements of collaboration listed, and if they wished, to suggest additional elements. The elements listed were: (1) including the family in decisions; (2) conveying a caring attitude; (3) sharing information in an open manner; (4) considering families' limits and responsibilities; (5) asking families for their views; (6) considering the cultural factors that influence the family/professional relationship; (7) considering all aspects of the child's life; (8) recognizing the family as a key resource; and (9) evaluating and changing services based on family's feedback. Both family member and professional respondents overwhelmingly agreed with the elements listed. A few of the respondents suggested that the elements provided were heavily weighted toward the professional's responsibilities in a collaborative relationship, and that the responsibilities of families should not be minimized.

Barriers to Collaboration. Respondents were asked to rate barriers to family/professional collaboration. A list of 20 potential barriers was provided in the questionnaire, and respondents rated each on a four-point Likert scale (e.g. 1=Never a Barrier, 2=Rarely a Barrier, 3=Sometimes a Barrier, 4=Often a Barrier). The mean ratings for each barrier for the families and professionals are presented in Table 2 below, rank ordered according to family respondents ratings. In general, family respondents felt that barriers occurred more frequently than did professionals. Families and professionals generally agreed that the three most frequent barriers to collaboration were: (1) professionals' lack of sufficient time to spend with families, (2) high caseloads, and (3) families' prior negative experiences with professionals. A comparison of family and professional ratings of the barriers, based upon t-tests for independent samples, revealed some statistically significant differences in the ratings of the two groups. Compared to professionals, family respondents rate each of the following as barriers occurring significantly more frequently:

- professionals believe that families cause disorders
- professionals expect too much of families
- professionals have inadequate knowledge of disorders
- families are socially isolated
- professionals and families disagree as to cause of child's disorder
- [an] inherent power imbalance [exists] between families and practitioners
- professionals lack sufficient time to spend with families
- agencies lack sufficient administrative support
- government policies require families to give up custody of their child to get services.

TABLE 2. Comparison of family and professional respondents' mean scores and standard deviations for ratings of barriers to collaboration

Variable	Family respondents		Professional respondents		
	M	*SD*	*M*	*SD*	*t*-value
Professionals lack sufficient time to spend with families	3.87	.34	3.41	.73	2.67[a]
Agencies staff have high caseloads	3.78	.42	3.52	.67	1.59
Families' prior negative experiences with professionals	3.71	.55	3.65	.49	0.37
Agencies lack sufficient administrative support	3.70	.47	2.86	.89	3.90[c]
Professionals believe that families cause disorders	3.67	.70	3.13	.69	2.63[a]
Inherent power imbalance between families and practitioners	3.65	.49	3.22	.74	2.36[a]
Government policies require family members to give up custody of their child to get services	3.64	.58	2.69	1.11	3.60[b]
Professionals have inadequate knowledge of disorders	3.63	.49	3.09	.51	3.66[b]
Professionals expect too much of family	3.50	.59	3.09	.42	2.76[b]
Professionals and families disagree as to cause of child's disorder	3.50	.59	3.00	.52	3.08[b]
Families are socially isolated	3.46	.51	2.87	.55	3.82[c]
Professionals' prior negative experiences with families	3.45	.51	3.22	.52	1.61
Professionals lack skill working with ethnically and culturally diverse populations	3.29	.69	3.39	.58	0.53
Families have inadequate knowledge of disorders	3.29	.69	3.22	.67	0.37
Families expect too much of professionals	3.17	.82	3.35	.65	0.84
Families don't follow through	3.17	.57	3.26	.54	0.58
Families don't use resources that are available	3.13	.69	3.17	.58	0.23
Professionals don't consider and respect different family characteristics and family types (e.g. step-families, single family member families, etc.	3.09	.43	3.04	.63	0.29
Families are involved with drugs and/or alcohol	3.05	.65	3.04	.37	0.01
Families are resistant or apathetic to receiving services	2.77	.61	2.86	.35	0.50

a=$p < .05$, *b*=$p < .01$, *c*=$p < .001$

The above differences notwithstanding, it is also important to note that for both groups the great majority of items received an average rating greater than three (Sometimes A Barrier). All but one of the items received average ratings greater than three by families and 80 percent of items received such ratings by professionals.

Contributors to Ability to Collaborate. Families and professionals were asked about the contributions of the family/professional training, additional training, reading, interactions with colleagues or other families, and life experiences to their ability to collaborate. Each of these items was rated on a four-point Likert scale (1=Not At All, 2=A Little, 3=Moderately, 4=Very Much). The ratings of the family and professionals respondents are presented in Table 3.

Once again, it will be noted that each of the items received an average rating greater than three. Of particular interest, the great majority of families and professionals rated the family/professional training and personal life experiences as the greatest contributors to their ability to collaborate. Twenty families, three of whom also attended the training as professionals, listed other experiences that contributed to their ability to collaborate. Most of the experiences listed were concerned with getting services and understanding what is was like to have a child with a disability.

Fifteen professionals, five of whom were also parents of children with emotional disabilities, also listed experiences that contributed to their ability to collaborate with families. The specific experiences cited by the professionals were: their work experience (n=7); having a child with an emotional disability (n=4); discussions with families (n=3); exposure to CASSP (n=2); and personal value system (n=1).

TABLE 3. Comparison of family and professional respondents' mean scores and standard deviations for ratings of contributions to ability to collaborate

	Family respondents		Professional respondents		
Variable	*M*	*SD*	*M*	*SD*	*t*-value
Family member/Professional Collaboration Training	3.67	.70	3.77	.53	0.57
Additional training	3.22	.85	3.15	.75	0.27
Reading related information	3.71	.55	3.32	.67	2.11[a]
Experiences with other families	3.75	.68	--	--	n/a
Discussions with colleagues	--	--	3.14	.65	n/a
Personal life experiences	3.78	.60	3.80	.52	0.10

a=$p < .05$, *b*=$p < .01$, c=$p < .001$

Qualitative Findings

Of the 44 people who were willing to be interviewed, 36 were contacted and interviewed. Of these, 16 of the 36 people interviewed were family members; 19 were professionals, and one was a dual respondent. The findings from the qualitative interview are presented below following each interview question which is presented in italics.

In our conversations with parents and professionals about collaboration, we have gotten the sense that some people believe that there are some professionals who have a collaborative instinct and there are other professionals who don't have this instinct. What do you think about that?

A little more than half of parents and professionals said that collaboration was due to personality, "instinct" and world view. Representative of this perspective were those respondents who believed that people who are collaborative have "real" concern for other people. One parent suggested that some people have greater sensitivity and empathy than other people, and consequently, are more collaborative. Several respondents felt that some professionals were collaborative because they had raised a child who had an emotional disability or had other personal experiences that had sensitized them to families' needs.

About one-third said education and training influenced collaboration. One parent said: "...it takes ongoing trainings. It takes more than instinct. It takes alot of work." One professional noted that "what I see needed is a dialogue [between] parents and professionals, where parents are teaching the professional how to be more parent-friendly."

In their responses to this question, some respondents gave opinions about why some professionals were not collaborative. One professional suggested that professionals who were not collaborative valued status and power. Another professional said that professionals feared jeopardizing their jobs and that the need for job security influenced their reluctance or refusal to collaborate with parents. This notion was supported by a professional who said that professionals may "ultimately work themselves out of a job by being collaborative." Several respondents also suggested that the length of time that a professional has been in the field may be a factor in the ability or desire to be collaborative. One respondent believed that those people who had been in the field for a number of years were more "rigid" and thus less collaborative than those professionals who had been working less time. Other respondents remarked that collaboration between parents and professionals was impeded by some professionals' inclination to blame parents for their children's emotional or behavioral disorders.

As a parent or professional who would like to engage in collaborative practice, have you experienced any negative consequences because of your attempts to collaborate?

Almost two-thirds of parents and one-half of professionals indicated that they had experienced negative consequences because of their attempts to collaborate. Many families cited their frustration due to professional inaction. One parent remarked "I find that...professionals are so busy watching what they say they don't have time to do anything." Another parent respondent commented, "when you want a service for your child and go after it, you are looked at as someone causing trouble. When I stood up for my child with disabilities...my child never really got the services that I thought he should have." A few noted that their children, both with and without disorders, were negatively affected by their attempts to be collaborative. Supporting this opinion was one parent who remarked "it is [as if] the kids whose parents speak up are on some kind of list and are watched." Other families cited the lack of seriousness with which their opinions were viewed as a negative consequence of their attempts to collaborate. A particularly frustrated parent believed "the more you try to learn the system and...make suggestions and approach things on a collaborative or equal basis, you're slapped down harder....We never got services to help him function as an adult." Some families also reported professionals distanced themselves as a result of their attempts to collaborate. Several family respondents noted that as they became more knowledgeable about their rights, some professionals were threatened and less likely to be collaborative.

Professionals also identified specific barriers that they had experienced. Many professionals experienced disrespect and negativity from some of their colleagues which resulted from their attempts to work collaboratively with families. One professional cited the belief that he was seen by colleagues as "championing" the needs of parents and consequently, not a "true or loyal professional."

Some professionals have told us that they feel as though they are unfairly criticized for their practices. Some call this "professional bashing." Do you think there is excessive "professional-bashing" occurring now?

Professionals and parents expressed the sentiment that while there is still some professional bashing occurring, it is not excessive. Still, slightly more parents than professionals believed that professional bashing was excessive. Both parents and professionals attribute some professional bashing to misunderstandings generated by a lack of communication. One professional suggested that families are often offended by the lack of sensitivity professionals display towards them and their child: "Professionals get so caught up in their...jargon that they don't know that what they are saying can hurt. It seems as though we are talking about an object. How did the doctor get away from his bedside manner?" Several respondents noted that parents' frustrations, anger and/or denial of a child's problems may lead to professional

bashing. Supporting this, one respondent suggested that parents "feel their hands are tied" and, consequently, it becomes "easy to hunt for someone to blame." Another professional interviewed, believed that some people are angry because of their life circumstances and tend to blame "anyone who can't help them."

Some professionals see the criticism that does exist, as warranted. But one professional cautioned colleagues to realize that the anger and criticism was based on frustration and not personally directed. Another professional suggested that the system itself generated dissatisfaction among professionals. This dissatisfaction influences the worker's motivation which consequently affects his or her working relationships with consumers. This professional claimed "the system is as dysfunctional as the family. We have a 50 percent turnover. These agencies don't treat their staff and employees with respect....They [the staff] feel like no one supports them, they're not paid enough, so that is brought to the client. Our client is suffering from our own stress."

Some interview participants have seen a decrease in the amount and degree of criticism of professionals in recent years. One professional's hypothesis for less bashing: "Parents and professionals are working under the framework of collaboration and so less bashing is occurring on either side."

In your experience with families or professionals, are there cultural factors which affect either the ability or desire to be collaborative?

The majority of both professionals and families agreed that a lack of sensitivity to cultural factors and differences is a major barrier to collaborative relationships. One professional suggested that trying to understand differences in cultural style creates frustrations for professionals. This professional suggested that strategies that work with one group may not work with another and that workers must be skilled at modifying strategies when working with people of diverse cultures. A related problem expressed by both families and professionals is that there are relatively few persons of color who are professionals and who have a deep appreciation for, and understanding of, cultural factors which may affect collaborative relationships. Overt racism was also cited by respondents as inhibiting collaboration between people of different cultures. One respondent said "with the African American family I feel there is still alot of prejudice. I've often witnessed a professional speaking about an African American male saying he'll be in the juvenile justice system before long." Another professional remarked about racism and bias: "a person combats this by being cognizant of what they bring into the relationship....Clinicians must be fully aware of prejudices that they bring into any situation." One parent believed that culture plays a major role in the inability to collaborate because minority families tend not to be involved politically, and therefore, do not participate in defining public policy or influencing political organizations. This parent stated

that few minority parents opened up "to share their thoughts." She believed that "although there are many people anxious to learn more about cultural feelings...there would still be some problems as far as collaborating....If people in those cultures are not available to be involved, it is going to make it more difficult." A professional expressing a similar opinion noted that there is a lack of "fair representation" of cultural diversity in parent organizations.

In addition to cultural bias or ignorance, many respondents pointed to the primary role of socioeconomic status and the differential treatment of low income families by providers and service systems. A parent made the comment, "poor people's level of intelligence is judged by their income. Professionals often take a paternalistic attitude that these people cannot take care of themselves." Due to the vulnerability that many low income families feel, they are sometimes suspicious of the power and motives of professionals.

Other factors such as linguistic differences, religious issues, and disadvantages in accessing services due to living in rural environments were also cited as being potential barriers to establishing effective collaboration. Many respondents, both parents and professionals suggested that open communication with people of diverse cultures, understanding one's own cultural awareness, developing sensitivity, and learning salient facts about cultures different from one's own will help to make collaboration between families and professionals of different cultures a reality.

There are some professionals who would argue that being collaborative is no more than being a good counselor or therapist. What do you think about this?

Is collaboration different than good professional practice? Wouldn't a truly skilled professional be collaborative? The majority of our respondents strongly disagreed. Both the families and professionals noted that collaboration differs from "good practice" because collaboration requires partnership, reciprocity and equality. One professional said, "I believe our job is to...teach families to advocate for the services they need. I think that we should be more or less putting ourselves out of the business...." Others viewed the difference in good practice and collaboration as how well people work as a team. For example, one professional said that "being able to collaborate is a team concept that is different from an individual concept....When you hire a therapist he may have great skills in counseling and in different types of therapy but he may not be a team member with parents or other professionals." Many respondents noted that no individual is more important than any other. One parent stated, "parents need to feel that they are not being put down, but are on the same level as the professional." Another parent remarked that "the concept that these people are professionals and that they know more than me goes away with collaboration."

DISCUSSION

This study had two purposes. One was to evaluate the *Working Together* curriculum. How was it experienced by the participants; was it worthwhile? Second, the study sought to gather information about the nature of family/professional collaboration from persons experienced in collaborative practice. Since each of the participants was trained in one curriculum and was attempting to work in a collaborative manner since the training, the study provided a unique opportunity to garner their experiences. One limitation of the study was its reliance on retrospective reporting, raising the possibility of inaccurate recall due to the time elapsed. However, this limitation was balanced by the benefits afforded by participants' experience in applying the training. The immediate feedback following the training had been almost entirely positive, but it necessarily was not based on actual practice, i.e., the participants had not had an opportunity to apply what they had learned. The focus of this study was to obtain a more pragmatic, experiential perspective.

Overall, the findings from the evaluation suggest that the participants in the training found it to be of great value. Individual components of the training were highly regarded. Specifically the identification of attitudinal and service system barriers, practicing various skills, demonstrations, exercises and hand-outs were all rated highly by respondents. In addition, respondents believed the training positively influenced their day-to-day practices as family members and professionals involved in children's mental health. For example, over one-half of the family and professional respondents indicated that their participation in the training influenced them to: assist a parent/family in dealing with the service system, contact a legislator about a children's mental health issue, and help organize a group to discuss or advocate for children's mental health issues.

Arguably the most interesting aspect of this survey was the feedback from participants concerning the nature of collaboration. These data were gathered using both quantitative and qualitative methods, and while there were some specific differences between the family and professional respondents, generally a strong consensus emerged regarding the nature of collaboration. Both family and professional respondents concurred regarding the elements of collaborative practice which have been proposed in the literature in recent years. Almost without exception respondents concurred with the following nine elements: (1) including the family in decisions; (2) conveying a caring attitude; (3) sharing information in an open manner; (4) considering family members' limits and responsibilities; (5) asking family members for their views; (6) considering the cultural factors that influence the parent/professional relationship; (7) considering all aspects of the child's life; (8) recognizing the family as a key resource; and (9) evaluating and changing services based on family's feedback. Regarding the influence of various factors on their ability to collaborate, respondents noted that the family/professional collaboration training and their own personal life experiences were the greatest contributors to their collaborative abilities.

The findings concerning barriers to collaboration were especially reflective of efforts to apply collaboration principles in practice. Of twenty potential barriers listed, family members and professionals agreed that the three greatest barriers to collaboration were: professionals' lack of time, high caseloads, and families' prior negative experiences with professionals. Addressing the third barrier first, families' prior negative experiences, may more accurately be a result of the lack of collaboration and may therefore be dependent upon the removal of other barriers. Professionals' lack of time and high caseloads are probably related and are more influenced by organizational policies and system factors than individual professional's attitudes or practices. There is a risk that as resources in human service continue to shrink and managed care becomes a reality, the demands put upon service providers will continue to increase and professionals' time and caseloads will become even greater barriers. Advocates and professionals must remain vigilant in their efforts to assure that such system changes do not come at the expense of improvements in family/professional collaboration.

The findings from the qualitative interviews generally corroborated the notion that collaboration is not a simple issue. Two controversial topics consistently raised in previous discussions were: (1) the instinctual v. learned nature of collaboration, and (2) whether there is a distinction between a collaborative working relationship and good professional practice. The survey respondents revealed a diversity of opinions on these topics. Roughly half felt collaboration was an instinct, and about one-third believed it could be acquired. Regarding the relationship of collaboration to good counseling, most felt collaboration was unique, but many also stated, or implied, that to be a good counselor a professional would need to be collaborative.

The qualitative interview also sought to assess whether respondents had experienced any negative consequences as a result of their efforts to collaborate and if the respondents believed that cultural factors influenced collaboration. It was interesting to note that both family members and professionals reported that attempts to collaborate led to negative consequences. Generally these consequences involved frustration, disrespect, and negativity, either from professionals with whom the families were working or from colleagues of professionals who were trying to collaborate. Family members noted that they would often not get the services their child needed as a consequence of their collaboration efforts. The comments here suggest that, despite the increasing acceptance of collaboration as a guiding principle for service delivery, traditional practices and attitudes still remain.

A degree of consensus was also found regarding the extent to which cultural factors influence collaboration. The majority of both family and professional respondents believed that a lack of sensitivity to diversity and cultural issues were major impediments. In addition to the lack of sensitivity, some respondents also noted the paucity of professionals from diverse cultures, general lack of knowledge about cultural issues, and the importance of socioeconomic status in

service delivery. Overall, the comments concerning cultural factors affirm the increasing attention that is being directed toward this issue.

Perhaps the single most dominant theme that emerges from the findings is that collaboration is only partially developed as a concept and only partially applied as a practice. There was consensus about what elements of collaboration are important but a range of opinions about how collaboration can be promoted and how much it is influenced by personal qualities. There were clear indications that various factors ranging from caseload characteristics to lack of knowledge still impede collaboration and that the rhetoric of recent years is not necessarily matched by actual events. What is needed is a second wave of efforts to bring the concept and practice of collaboration to a higher level of development. Issues such as collaboration with families who have substance use or child abuse problems, the re-definition of professionalism in a collaborative context, and the identification of optimal collaboration training methods will require more attention if the concept is to become integral to the helping professions. Research efforts must continue to study the experiences of family members and professionals--such as the survey respondents described here-- who are attempting to make collaboration work in the real give-and-take of human service settings. Above all, the development of the concept and practice of collaboration requires a refinement of basic values. Within any transition from one set of values to another, there is a tendency to accentuate differences as points of departure. In the evolution of collaboration in the human services, what is needed now is an emphasis on differences as strengths. To the extent that families and professionals can see beyond the differences that divide and, instead, identify strengths in those differences, the concept and practice of collaboration will continue to mature.

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APPENDIX I

PARENT/PROFESSIONAL COLLABORATION SURVEY

This survey is intended to obtain information concerning your experiences following the parent/professional collaboration training that you received from the Portland Research and Training Center. Your responses and those of others who received the training will be used to further enhance our efforts to identify the essential elements of collaboration and improve the training. In addition, this survey is an opportunity for you to retrospectively evaluate both the content of the training and its usefulness for you as a participant.

I. TRAINING

We would like to get your thoughts on effective methods for training parents and professionals to collaborate.

How important do you consider each of the following components in such a training? *(Circle one response for each.)*

1. Identification of attitudes which are barriers to collaboration.	NOT IMPORTANT	SLIGHTLY IMPORTANT	SOMEWHAT IMPORTANT	VERY IMPORTANT
2. Identification of service system barriers to collaboration.	NOT IMPORTANT	SLIGHTLY IMPORTANT	SOMEWHAT IMPORTANT	VERY IMPORTANT
3. Practicing interpersonal communication skills.	NOT IMPORTANT	SLIGHTLY IMPORTANT	SOMEWHAT IMPORTANT	VERY IMPORTANT
4. Practicing problem solving/ negotiation skills.	NOT IMPORTANT	SLIGHTLY IMPORTANT	SOMEWHAT IMPORTANT	VERY IMPORTANT
5. Developing strategies to promote collaborative practice.	NOT IMPORTANT	SLIGHTLY IMPORTANT	SOMEWHAT IMPORTANT	VERY IMPORTANT
6. Demonstration of collaborative skills by trainers.	NOT IMPORTANT	SLIGHTLY IMPORTANT	SOMEWHAT IMPORTANT	VERY IMPORTANT
7. Group exercises.	NOT IMPORTANT	SLIGHTLY IMPORTANT	SOMEWHAT IMPORTANT	VERY IMPORTANT
8. Handouts and other written material.	NOT IMPORTANT	SLIGHTLY IMPORTANT	SOMEWHAT IMPORTANT	VERY IMPORTANT
9. Practicing skills for personal advocacy.	NOT IMPORTANT	SLIGHTLY IMPORTANT	SOMEWHAT IMPORTANT	VERY IMPORTANT
10. Practicing skills for system advocacy.	NOT IMPORTANT	SLIGHTLY IMPORTANT	SOMEWHAT IMPORTANT	VERY IMPORTANT

11. What other major concepts or skill areas should be addressed in this type of training?

_____

_____

_____

_____

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Thinking back on the training you received from the Portland Research and Training Center . . .

12. Overall, what were the most important skills and information you learned?

_____
_____
_____
_____

13. What were the greatest weaknesses of the training? _____
_____
_____
_____

14. How many other people have you trained? _____

II. ACTIVITIES

Below are a number of activities in which you may have been involved. Next to each activity indicate if you have done it. **If yes**, indicate whether your involvement was influenced by the training.

ACTIVITY	HAVE YOU DONE THIS?		IF YES, INFLUENCED BY TRAINING?	
	Yes	No	Yes	No
• Became a board member of a mental health or social service agency	___	___	___	___
• Joined a parent support group	___	___	___	___
• Became a member of an advisory group or task force concerned with children's mental health	___	___	___	___
• Joined the Federation of Families for Children's Mental Health, the National Alliance for the Mentally Ill-Child and Adolescent Network, or other national organizations	___	___	___	___
• Phoned, wrote to, or visited a legislator to talk about children's mental health issues	___	___	___	___
• Phoned, wrote to, or visited an agency or school administrator about the services a child should be receiving	___	___	___	___
• Prepared or gave testimony to a legislative committee regarding children's mental health	___	___	___	___
• Attended a meeting or hearing to express my feelings about children's mental health services	___	___	___	___
• Gave a speech or wrote an article about children's mental health	___	___	___	___
• Assisted another parent/family in dealing with the service system	___	___	___	___

	HAVE YOU DONE THIS?		IF YES, INFLUENCED BY TRAINING?	
	Yes	No	Yes	No
• Have been involved in legal or court action regarding services for children	___	___	___	___
• Filed a formal complaint or grievance regarding services for children	___	___	___	___
• Helped organize a group to discuss or advocate for children's mental health issues	___	___	___	___

III. ELEMENTS OF COLLABORATION

Listed below are what we consider the major elements of collaboration. If you think one of these does not belong, *cross it out and tell us why*. If you think other things belong, please let us know by adding them to the end of the list.

- Including the family in decisions

  If no, why?

- Conveying a caring attitude

  If no, why?

- Sharing information in an open manner

  If no, why?

- Considering family members' limits and responsibilities

  If no, why?

- Asking family members for their views

  If no, why?

- **Considering the cultural factors that influence the parent/professional relationship**

  If no, why?

- **Considering all aspects of the child's life**

  If no, why?

- **Recognizing the family as a key resource**

  If no, why?

- **Evaluating and changing services based on family's feedback**

  If no, why?

I would add to the list:

-
-
-

IV. BARRIERS TO COLLABORATION

In talking with families and professionals we've begun to identify barriers to collaboration. Based on your own experience and what you have observed in others, please rate how often each of the following is a barrier to parent/professional collaboration. *(Circle one response for each statement.)*

1. Professional's belief that family interaction is a major factor in child's disorder.	NEVER A BARRIER	RARELY A BARRIER	SOMETIMES A BARRIER	OFTEN A BARRIER
2. Professional expects too much of family.	NEVER A BARRIER	RARELY A BARRIER	SOMETIMES A BARRIER	OFTEN A BARRIER
3. Professional has inadequate knowledge of child's disorder.	NEVER A BARRIER	RARELY A BARRIER	SOMETIMES A BARRIER	OFTEN A BARRIER
4. Professional lacks skill in working with ethnically and culturally diverse populations.	NEVER A BARRIER	RARELY A BARRIER	SOMETIMES A BARRIER	OFTEN A BARRIER

5. Professional doesn't consider and respect different family characteristics and family types (e.g., step-families, single-parent families, etc.).	NEVER A BARRIER	RARELY A BARRIER	SOMETIMES A BARRIER	OFTEN A BARRIER
6. Professional has had negative prior experiences with families.	NEVER A BARRIER	RARELY A BARRIER	SOMETIMES A BARRIER	OFTEN A BARRIER
7. Family doesn't use resources that are available.	NEVER A BARRIER	RARELY A BARRIER	SOMETIMES A BARRIER	OFTEN A BARRIER
8. Family has had negative experiences with professionals and service system.	NEVER A BARRIER	RARELY A BARRIER	SOMETIMES A BARRIER	OFTEN A BARRIER
9. Family expects too much of professionals and service system.	NEVER A BARRIER	RARELY A BARRIER	SOMETIMES A BARRIER	OFTEN A BARRIER
10. Family has inadequate knowledge of child's disorder.	NEVER A BARRIER	RARELY A BARRIER	SOMETIMES A BARRIER	OFTEN A BARRIER
11. Family is socially isolated.	NEVER A BARRIER	RARELY A BARRIER	SOMETIMES A BARRIER	OFTEN A BARRIER
12. Family doesn't follow through.	NEVER A BARRIER	RARELY A BARRIER	SOMETIMES A BARRIER	OFTEN A BARRIER
13. Family is involved with drugs and alcohol.	NEVER A BARRIER	RARELY A BARRIER	SOMETIMES A BARRIER	OFTEN A BARRIER
14. Family is resistant or apathetic to receiving services.	NEVER A BARRIER	RARELY A BARRIER	SOMETIMES A BARRIER	OFTEN A BARRIER
15. Professional and family disagree as to cause of child's disorder.	NEVER A BARRIER	RARELY A BARRIER	SOMETIMES A BARRIER	OFTEN A BARRIER
16. There is an inherent power imbalance between practitioner and family.	NEVER A BARRIER	RARELY A BARRIER	SOMETIMES A BARRIER	OFTEN A BARRIER
17. Agency staff have high caseloads.	NEVER A BARRIER	RARELY A BARRIER	SOMETIMES A BARRIER	OFTEN A BARRIER
18. Agency staff don't have enough time available for families.	NEVER A BARRIER	RARELY A BARRIER	SOMETIMES A BARRIER	OFTEN A BARRIER
19. Agency staff don't have enough administrative support.	NEVER A BARRIER	RARELY A BARRIER	SOMETIMES A BARRIER	OFTEN A BARRIER
20. Government policies require parents to give up custody of their child to get services.	NEVER A BARRIER	RARELY A BARRIER	SOMETIMES A BARRIER	OFTEN A BARRIER

21. Other barriers to collaboration: *(Please identify)* _____

_____

_____

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V. Did you attend the training as a:
____ parent
____ professional

If you attended as a *parent*, please complete this box:

1. **Your child's birthdate? (the child with the emotional disability) (month/day/year)**
_____/_____/_____

2. Your child's sex? *(Check one)*
____ Female
____ Male

3. Your child's race? *(Check one)*
____ African American
____ Asian American or Pacific Islander
____ Hispanic or Latino American
____ Native American
____ White
____ Other: _____

4. How old was this child when you first looked for treatment? _____ years

5. How are you related to this child? *(Check one)*
____ Birth or adoptive mother
____ Birth or adoptive father
____ Stepmother
____ Stepfather
____ Foster mother
____ Foster father
____ Grandmother
____ Other: _____

(Go to #6 below)

6. To what degree has each of the following contributed to your ability to collaborate with families who have a child with a serious emotional disorder? *(Circle one response for each.)*

a. Parent/professional training.	NOT AT ALL	A LITTLE	MODERATELY	VERY MUCH
b. Additional training.	NOT AT ALL	A LITTLE	MODERATELY	VERY MUCH
c. Things I have read.	NOT AT ALL	A LITTLE	MODERATELY	VERY MUCH
d. Experiences with other families.	NOT AT ALL	A LITTLE	MODERATELY	VERY MUCH
e. Personal life experiences.	NOT AT ALL	A LITTLE	MODERATELY	VERY MUCH

Please specify: _____
_____
_____

f. Other: _____	NOT AT ALL	A LITTLE	MODERATELY	VERY MUCH
g. Other: _____	NOT AT ALL	A LITTLE	MODERATELY	VERY MUCH

If you attended as a *professional*, please complete this box:

7. What is your professional title? *(Check one)*
   - ____ Social Worker
   - ____ Psychiatrist
   - ____ Psychologist
   - ____ Nurse
   - ____ Teacher
   - ____ Physician
   - ____ Lawyer
   - ____ Case Manager
   - ____ Other: _____

8. What type of organization do you work in? *(Check one)*
   - ____ Medical
   - ____ Mental health
   - ____ Child welfare
   - ____ Juvenile justice or courts
   - ____ Educational
   - ____ Residential treatment facility
   - ____ Private practice
   - ____ Other: _____

9. What is your *primary* job function? *(Check one)*
   - ____ Administration
   - ____ Counseling/Therapy
   - ____ Teaching
   - ____ Other: _____

10. How long have you been working with families whose children have serious emotional disorders? _____ years

11. Your gender? *(Check one)*
    - ____ Female
    - ____ Male

12. Your race? *(Check one)*
    - ____ African American
    - ____ Asian American or Pacific Islander
    - ____ Hispanic or Latino American
    - ____ Native American
    - ____ White
    - ____ Other: _____

13. Your highest degree acheived?

    _____

14. Discipline of your degree?

    _____

(Go to #15 Below)

15. To what degree has each of the following contributed to your ability to collaborate with families who have a child with a serious emotional disorder? *(Circle one response for each.)*

a. Parent/professional training.	NOT AT ALL	A LITTLE	MODERATELY	VERY MUCH
b. Discussions with colleagues.	NOT AT ALL	A LITTLE	MODERATELY	VERY MUCH
c. Additional training.	NOT AT ALL	A LITTLE	MODERATELY	VERY MUCH
d. Things I have read.	NOT AT ALL	A LITTLE	MODERATELY	VERY MUCH
e. Personal life experiences.	NOT AT ALL	A LITTLE	MODERATELY	VERY MUCH

Please specify: _____

_____

_____

f. Other: _____	NOT AT ALL	A LITTLE	MODERATELY	VERY MUCH
g. Other: _____	NOT AT ALL	A LITTLE	MODERATELY	VERY MUCH

ADDITIONAL COMMENTS: *(Please use this space for any other comments you have regarding family/professional collaboration and/or the training you received.)*

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Family/Professional Collaboration

The Perspective of Those Who Have Tried

EVALUATION FORM

1. Who used the report? (Check all that apply.)

   ❑Parent ❑Educator ❑Child Welfare Worker

   ❑Juvenile Justice Worker ❑Mental Health Professional

   ❑Other (Please Specify)_____

2. Please describe the purpose(s) for which you used the report:

   _____

   _____

3. Would you recommend use of the report to others? (Check one)

   ❑Definitely ❑Maybe ❑Conditionally ❑Under No Circumstances

   Comments:_____

4. Overall, I thought the report was: (Check one)

   ❑Excellent ❑Average ❑Poor

   Comments:_____

5. Please offer suggestions for the improvement of subsequent editions of this report:

   _____

   _____

   _____

   _____

We appreciate your comments and suggestions. Your feedback will assist us in our effort to provide relevant and helpful materials. Thank you.

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